Mail or fax this form to:

WomanCare OB/GYN
301 Gordon Gutmann Blvd – Suite 201
Jeffersonville, IN 47130
812-282-6114 phone/812-650-5315 fax

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient | Date of Birth | Daytime Phone Number

Home Address | City | State | Zip Code

____ I authorize **WomanCare** to OBTAIN my medical information FROM:

Name of Facility

Phone Number

Fax Number

____ I authorize **WomanCare** to DISCLOSE my medical information TO:

Name of Facility

Phone Number

Fax Number

Information to be OBTAINED or DISCLOSED:

____ Diagnostic testing's
____ Pap smear reports
____ Labs
____ Hospital records
____ Current OB records
____ Other, _____
____ Entire Medical Chart dated from _____ to today's date

Purpose to OBTAIN or DISCLOSE my medical information: ____ Continuity of Care ____ Personal Use

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to your office. I understand that a revocation is not effective to the extent that your office had relied on the use or the disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Your office will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:
**Refuse to sign this authorization*
**Receive a signed copy of this authorization*
**Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)*

This authorization shall be in force and effective until _____ at which time this authorization to use or disclose this protected health information expires. **Please specify a date or event that relates to the patient or purpose of the use or disclosure.

Signature of patient or Legal Guardian | Date | XXX-XX_____ Patient Social Security Number